Application for License to Operate a Health Facility or Service

For Office Use Only
Received _____
Amount _____

I. IDENTIFICATION

Name _____

Address _____

City/County/Zip _____

Telephone number _____

Administrator _____

Date facility operation began at current address _____

Date facility began operation under current owner _____

II. CONTROL (check one in each column)

State	Profit	Individual
County	Nonprofit	Partnership
City		Corporation
Private		

II. OWNERSHIP

Name and address of individual owner, partner or corporation

_____

_____

_____

If facility is owned by a corporation, complete the following:

Name of corporation _____

Address of corporation _____

President or Chairman _____

Vice President _____

Secretary _____

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

(OVER)

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

IV. SERVICE AREA (if applicable)

Area served _____

_____

_____

V. TYPE OF FACILITY OR SERVICE

_____ Adult Day Health Care Program
_____ Adult Day Health Care Program (providing nursing services)
_____ Alternative Birthing Center
_____ Ambulatory Care Clinic
_____ Ambulatory Surgical Center
_____ Chemical Dependency Treatment Service
_____ Community MH/MR Center
_____ Group Home (MR/DD)
_____ Group Home for Persons With Acquired Brain Injuries
_____ Health Maintenance Organization
_____ Hospice
_____ Network (list addresses of extensions on separate page)
_____ Nursing Pool
_____ Private Duty Nursing Agency
_____ Psychiatric Residential Treatment Facility
_____ Prescribed Pediatric Extended Care Service
_____ Primary Care Center or Satellite
_____ Rehabilitation Agency (Outpatient)
_____ Renal Dialysis
_____ Rural Health Clinic

Other _____

I understand that any change in the application that affects my licensure status will be reported to the Division of Community Health Services and a new application will be completed at that time. I agree that this service and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of Authorized Representative	Title	Date

Return Application and Fee To:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 144
(10/2002)